

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3

REG. NO.

1 3 6 2 9

1. DECEASED NAME (TYPE OR PRINT)			FIRST Oscar	MIDDLE Charles	LAST Abbate	2a. DATE OF DEATH May 30, 1983	MONTH JUN	DAY 10	YEAR 1983	2b. HOUR M
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH NOV. 16, 1911 YEAR PAY	6. AGE (IN YEARS LAST BIRTHDAY) 71		IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mo. Tenn.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent County				
10. CITY OR TOWN OF DEATH Rock Hall			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at his home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) painter and carpenter		12b. KIND OF BUSINESS OR INDUSTRY MD.			
13a. STATE Md.			13b. COUNTY Kent	13c. CITY OR TOWN Rock Hall	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Rt. 1 Rural Route 21661				
14. FATHER'S NAME FIRST Nicholas			MIDDLE G.	LAST Abbate	15. MOTHER'S MAIDEN NAME FIRST Barbara		LAST Schaefer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-14-5749		17. INFORMANT Mrs. Angeline Van Sant, Rock Hall, Md. 21661		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Myocardial Enlargement - synder Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Enlargement, heart disease years Due to, or as a consequence of (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Diabetes Mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) <input type="checkbox"/> attended the deceased from 8, 1982, to 5/27, 1983, that (I) <input type="checkbox"/> last saw the deceased alive on 5/27, 1983, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE Wayne D Benjamin MD									DEGREE	
22c. DATE SIGNED 5/31/83										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D Benjamin, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS Chesertown Md 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 2, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Holy Reedemer Cemetery		23d. LOCATION CITY OR TOWN Balto. City	COUNTY	STATE		
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home P.A.		25a. DATE REC'D. BY REGISTRAR JUN 10 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield						

South - Cedar Creek, July 2000
many small birds and mammals

Additional notes

1

28 15/2 58 28 58 15/2

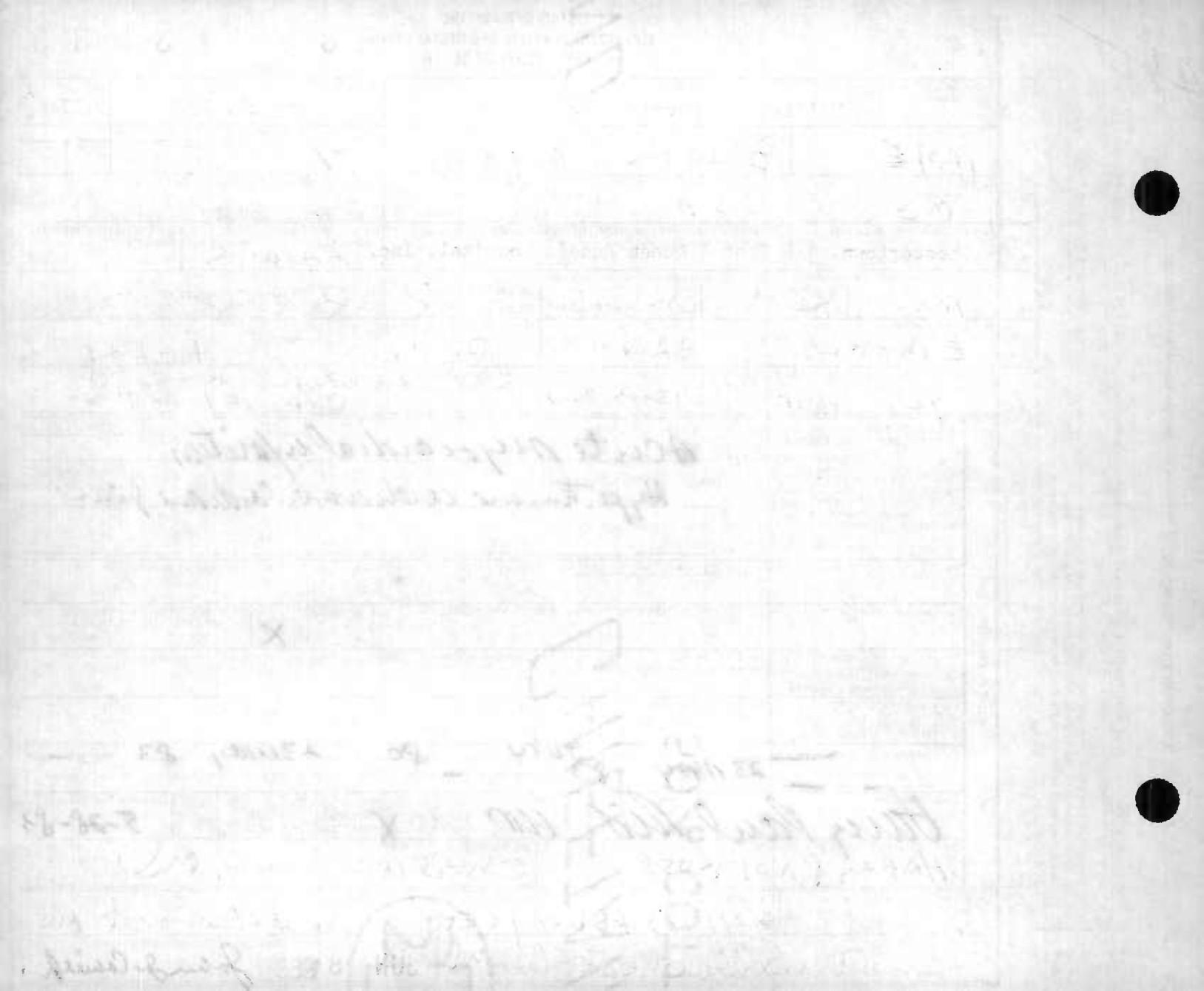
20/12/2018 - X 30 mm diameter 20 mm height 30 mm
width 6 mm thickness 2 mm height 30 mm width 30 mm

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

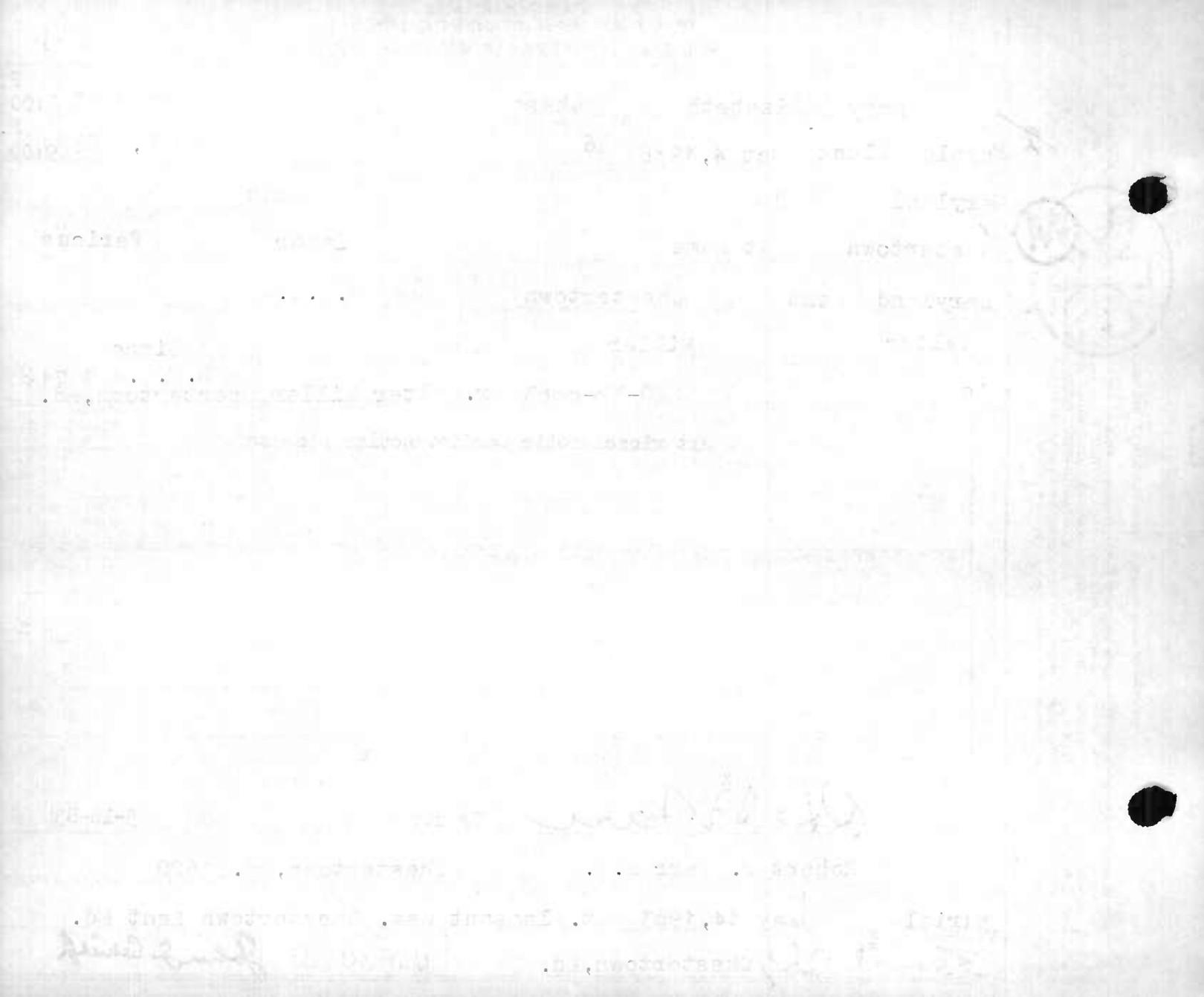
IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	3	1	3	6	3	0
												REG. NO. 13630						
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR A.M./P.M.						
			William Maurice Brown						May 23, 1983			9:37 A.M.						
3. SEX MALE			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR MAY 7, 1912			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent County			MD.						
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital, Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE MD			13b. COUNTY KENT			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 21620						
14. FATHER'S NAME FIRST MIDDLE LAST Emmons Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Henry			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 215-03-7427			17. INFORMANT ADDRESS Mrs. Clara Brown Ross Chestertown, MD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (d) and (c).) PART I. DEATH WAS CAUSED BY: 4100			DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cardiovascular disease years			DUE TO, OR AS A CONSEQUENCE OF (c)												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (the hospital) attended the deceased from TUES , 19 83 , to 23 May , 19 83 , that (I) (we) last saw the deceased alive on 23 May , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE Harry Paul Ross			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5-28-83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Paul Ross			22e. ADDRESS Chestertown, MD															
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 5/28/1983			23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cem.			23d. LOCATION CITY OR TOWN Chestertown, Kent Co.			COUNTY			STATE			
24. FUNERAL DIRECTOR Kenneth Walker			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR JUN 8 1983			25b. REGISTRAR'S SIGNATURE John J. Conigli									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 3 6 3 1				
1 - STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR			2b. HOUR <input type="checkbox"/>				
			Mary Elizabeth Chase						OF ESTI- DEATH MATED <input type="checkbox"/> May 9 1983 8:00am							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR <input type="checkbox"/>	
Female		Black		Oct 4, 1936		46 yrs.						May 9, 1983 9:00am				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA										Kent				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown		At Home						Labor						Various		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				21620				
Maryland		Kent		Chestertown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.F.D.#								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST						Sisco				
Walter				Miller		Edna						R.F.D. # 2 716				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> No		16b. SOCIAL SECURITY NO. 220-32-8863						17. INFORMANT		ADDRESS Mr. Walter Miller Chestertown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER				
ACTUAL SIGNATURE		<i>R. W. Farr</i>										DATE SIGNED 5-16-83				
EXAMINER'S NAME (TYPE OR PRINT)		Robert W. Farr M.D.										ADDRESS Chestertown, Md. 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE May 14, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant Cem.			23d. LOCATION CITY OR TOWN Chestertown		COUNTY Kent		STATE Md.			
Burial																
24. FUNERAL DIRECTOR NAME		ADDRESS Chestertown, Md.										25a. DATE REC'D. BY REGISTRAR MAY 20 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>		
Benedict																
DHMH - 17 (VR A15 ME (5)) 15M 2/80																

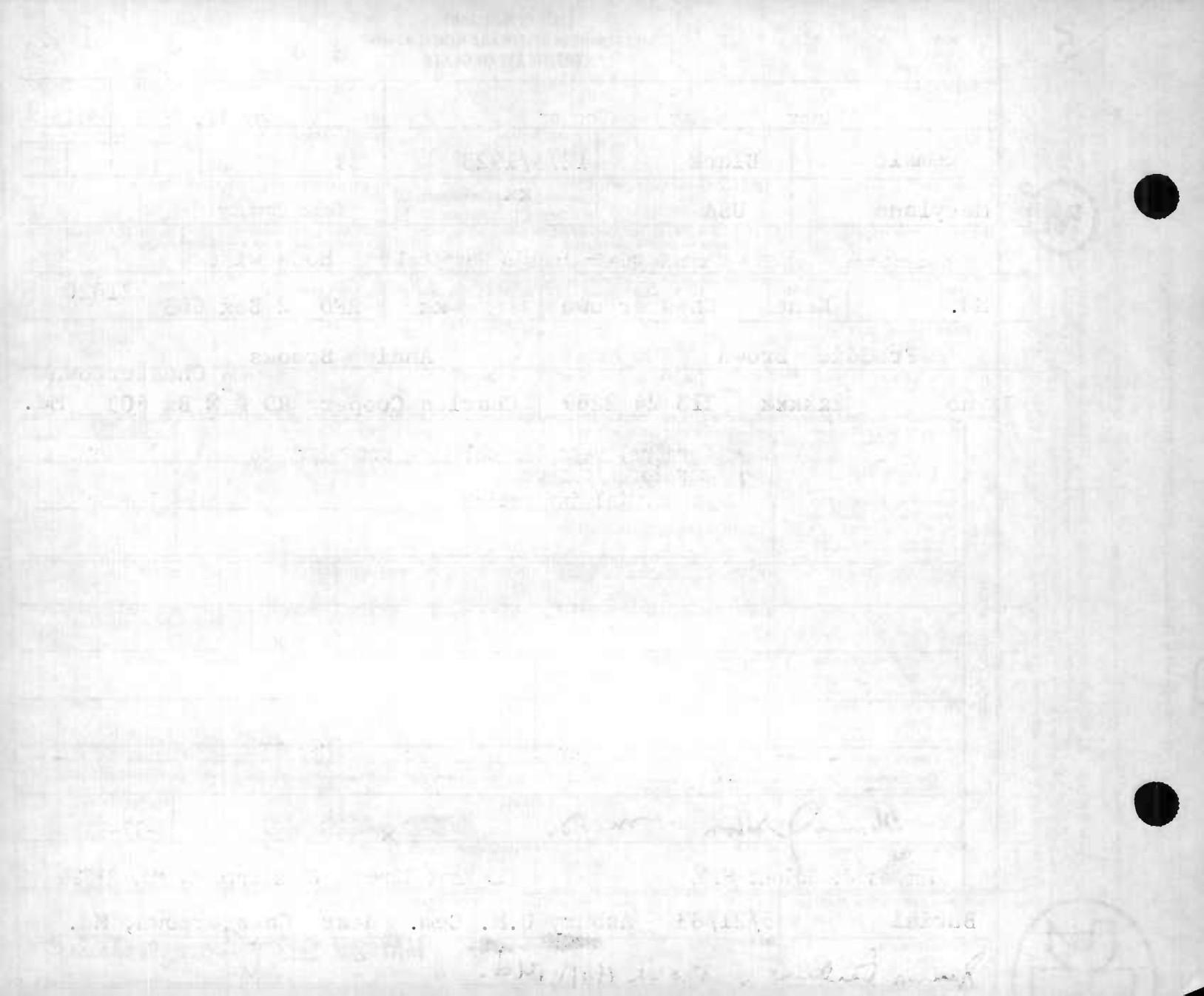


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Elinor			May	Cooper		May 17			1983			9:15 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		Black		12/5/1923		59			MONTHS	YEARS	MONTHS	HOURS
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		USA				Kent County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		The Kent & Queen Anne's Hospital		Housewife								
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD 2 Box 603		21620		
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Freddie		Brown			Annie		Brooks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS					
no		213 24 2269		Charles Cooper			2 Chestertown RD # @ Bx 603 Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular collapse secondary to cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour												1 hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (was hospital) attended the deceased from May 8, 1983, to May 17, 1983, that (I) (was not) saw the deceased alive on May 17, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Thomas J. Solon</u> M.D.		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-17-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				500 Kent Street, Chestertown, Md. 21620						
Thomas J. Solon, M.D.												
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5/21/83		23c. NAME OF CEMETERY OR CREMATORIAL Asbury U.M. Cem.		23d. LOCATION CITY OR TOWN near Chestertown, Md.		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <u>James Pertine</u>		ADDRESS <u>Rock Hall, Md.</u>		25a. DATE RECEIVED BY REGISTRAR MAY 27 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Daniels</u>						



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR			REG. NO. 1 3 6 3 3														
1. DECEASED NAME (TYPE OR PRINT)			FIRST ALLEN E GSELL			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR 5/1/83 19		
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR 12/9/40			6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN			2b. HOUR 10:45 P		
7a. BIRTHPLACE Kent Co. Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			2d. HOUR 12:20 P		
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At home Broad Neck RFD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY 21620								
13a. STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD Broad Neck					
14. FATHER'S NAME Edward Gsell			15. MOTHER'S MAIDEN NAME Mary Hurd														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes			16b. SOCIAL SECURITY NO. 216 38 8164			17. INFORMANT Mary Gsell			ADDRESS RFD Broad Neck Md.								
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I DEATH WAS CAUSED BY:</p> <p>9554 IMMEDIATE CAUSE (a) Gunshot wound of head</p> <p>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</p> <p>(b) DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) DUE TO, OR AS A CONSEQUENCE OF</p>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).</p>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:45A. 5-1 19 83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self-inflicted gunshot wound to head			21d. LOCATION STREET Foxpoint Farm, Chestertown, Kent, Maryland			CITY OR TOWN COUNTY STATE					
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21g. TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER			DATE SIGNED 5/1/83								
<p>22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>, and in my opinion</p>																	
ACTUAL SIGNATURE <i>Robert W. Farr</i>			EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr Chestertown - Kent Co. Maryland														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/3/83			23c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.			COUNTY STATE					
24. FUNERAL DIRECTOR NAME <i>John Willis Wells</i>			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE MAY 5 1983 <i>John J. Conner</i>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PRINT "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
15M7/77

REVIEW OF THE LITERATURE

and 132 11-20 180 1810 1820

High carbon content

lead or major economic difficulties, and

thus, does not have one solution.

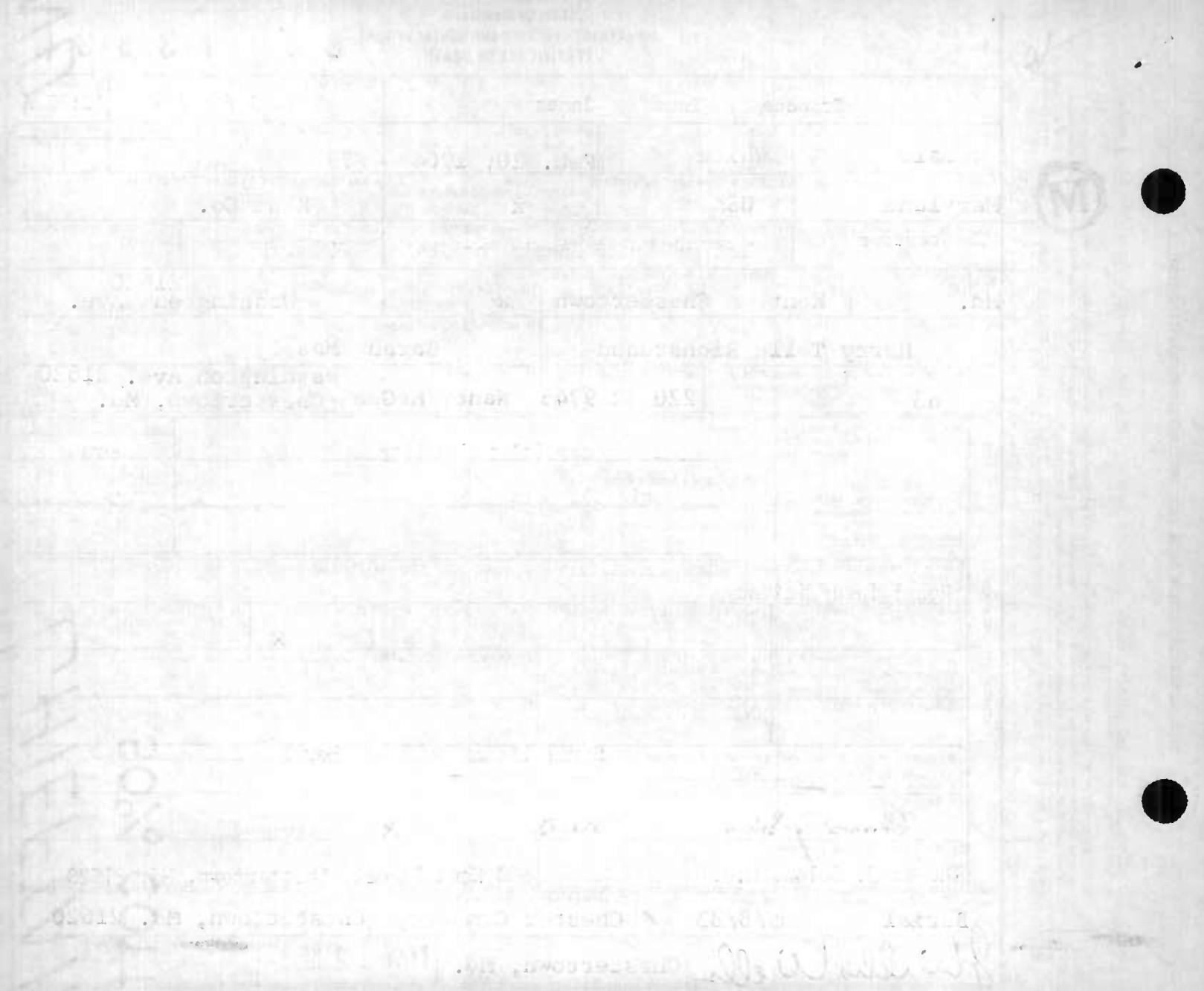
David Gandy 889 891

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 3 6 3 4	REG. NO.				
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST Frances	MIDDLE Inez	LAST Jones	2a. DATE OF DEATH			MONTH 5	DAY / 6 / 83	YEAR	2b. HOUR 12:57 A M		
3. SEX female			4. RACE White			5. DATE OF BIRTH MONTH Feb.			DAY 20,	YEAR 1904	6. AGE (IN YEARS LAST BIRTHDAY) 79			IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co.			MD.					
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 21620 Washington Ave.					
14. FATHER'S NAME FIRST Harry			MIDDLE Telle			LAST Richardson			15. MOTHER'S MAIDEN NAME FIRST Sarah			MIDDLE Massey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 32 9745			17. INFORMANT Nancy McGee			ADDRESS Washington Ave. 21620 Chestertown, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. { DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Renal insufficiency																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>April 14</u> , 19 <u>83</u> , to <u>May 6</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>May 6</u> , 19 <u>83</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.												22c. DATE SIGNED					
22b. SIGNATURE Thomas J. Solon			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas J. Solon, M.D.			22e. ADDRESS 500 Kent Street, Chestertown, Md. 21620														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/8/83			23c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md. 21620								
24. FUNERAL DIRECTOR NAME John Willis Wells			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR MAY 12 1983			25b. REGISTRAR'S SIGNATURE John J. Cahill								

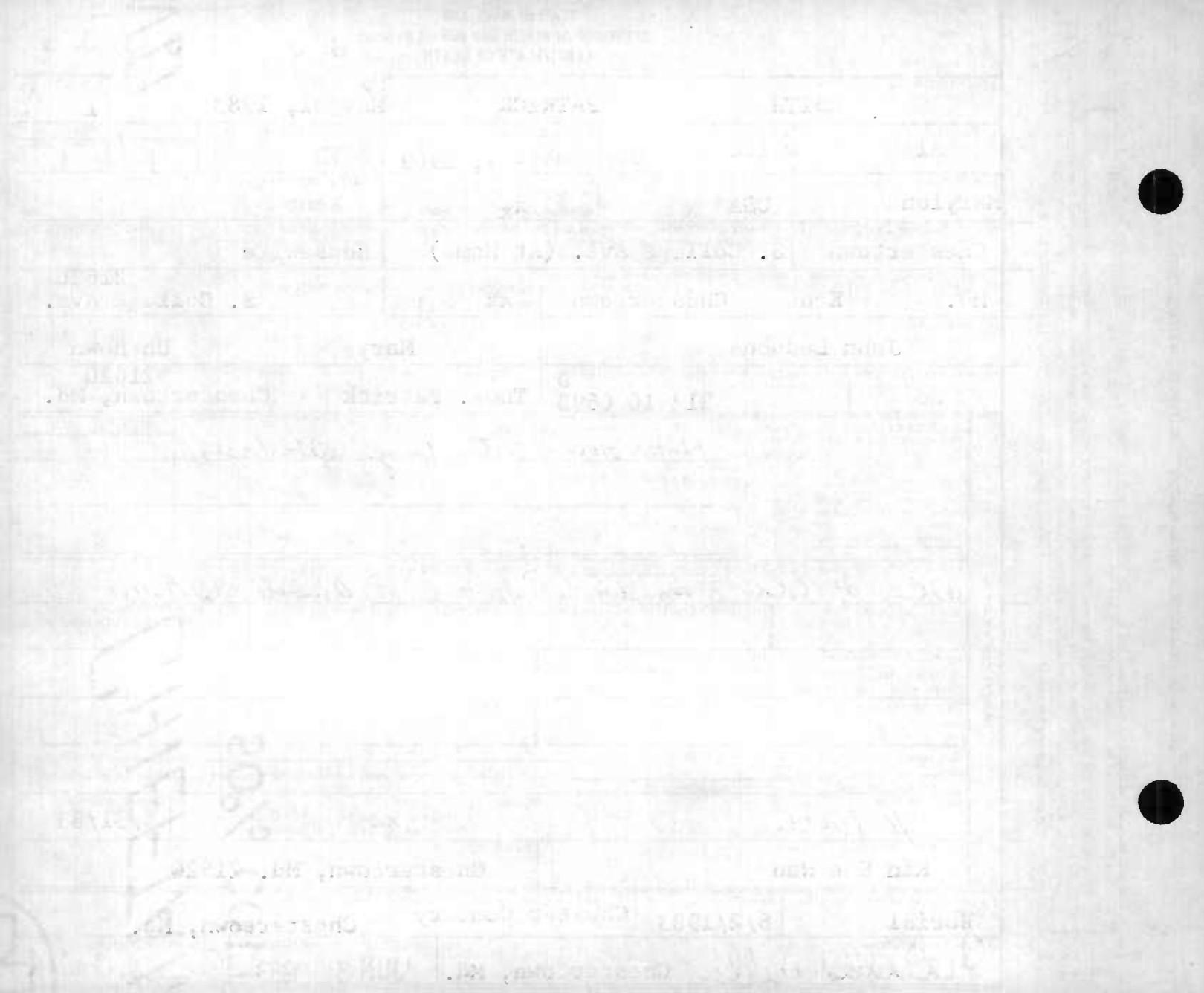


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Rule 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	1	3	6	3	5	
										REG. NO. 8313635							
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			EDITH						PATRICK	May 31, 1983						A 1 M	
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH September DAY 7, YEAR 1909			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent								
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. College Ave. (At Home)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		MD. 21620 S. College Ave.			
13a. STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
14. FATHER'S NAME FIRST John Leddon			MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST Mary						LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 412 10 0693			17. INFORMANT Thos. Patrick			ADDRESS 21620 Chestertown, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatoma with lung metastasis</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1550 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____																	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ①Ca of colon c lymphnode metastasis ②Diabetes ③ASHD																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Kin Kue Wun</u>										DEGREE				ATTENDING <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/31/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kin Kue Wun										22e. ADDRESS Chestertown, Md. 21620							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/2/1983			23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.			COUNTY		STATE			
24. FUNERAL DIRECTOR NAME <u>J. Wilhite Wells</u>			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR JUN 3 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>								



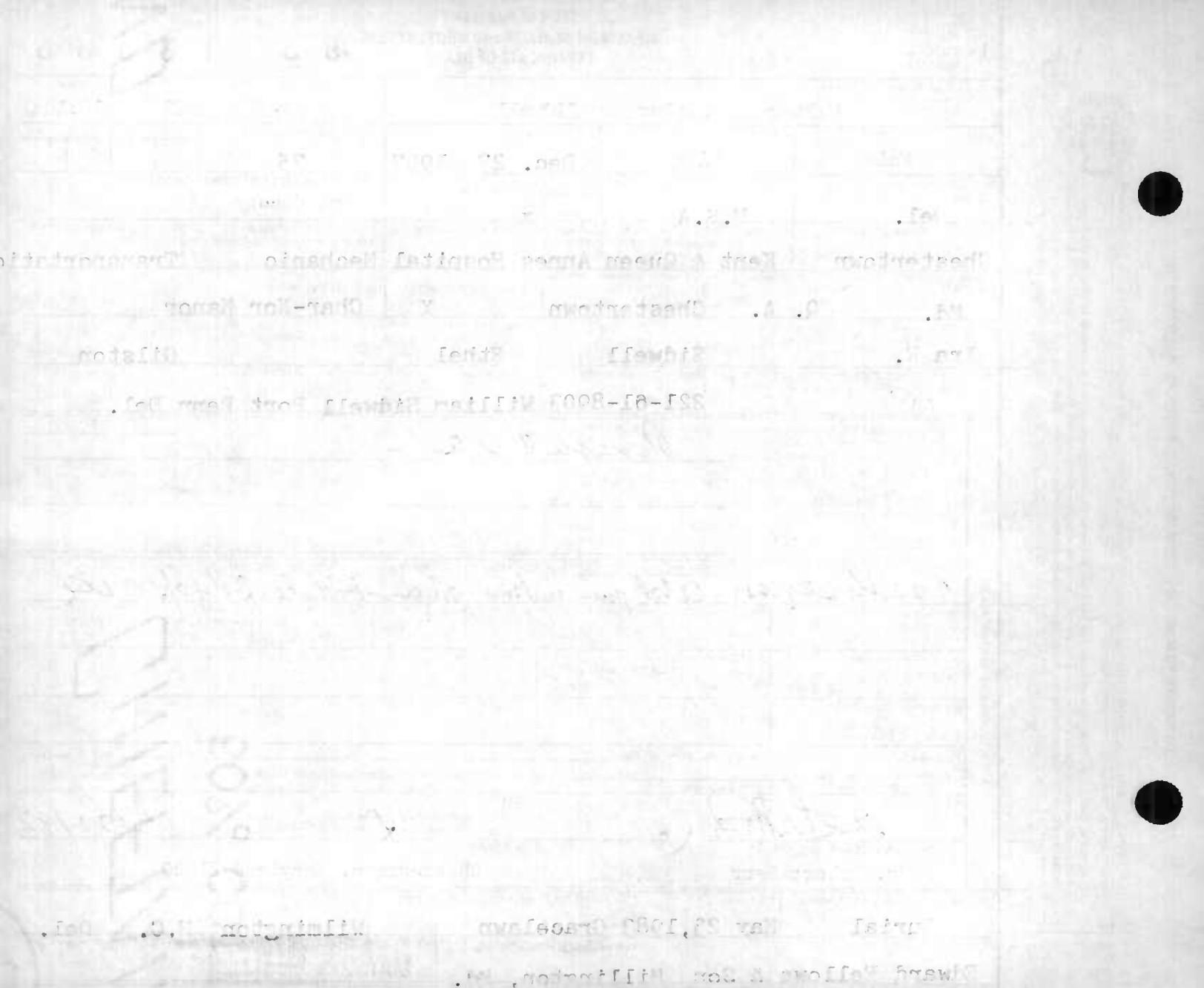
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use or the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 REG. NO. 1 3 6 3 6				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Walter Reisler Sidwell						May 20, 1983						10:10a _m		
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH Dec. DAY 27 YEAR 1907			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Del.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent County			MD.			
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Transportation						
13a. STATE Md.			13b. COUNTY Q. A.		13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Char-Nor Manor 21620			
14. FATHER'S NAME FIRST Ira W.			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Ethel			16. SOCIAL SECURITY NO. 221-01-8903			17. INFORMANT William Sidwell Port Penn Del.			
18. CAUSE OF DEATH (Enter only one cause per line for items b), and c PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION Assisted suicide - aid pain euthanasia - Did not left care			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NOT WHILE AT WORK			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			21d. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)														
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										22c. DATE SIGNED 5/22/83				
22b. SIGNATURE <i>Dr. Robert Farr</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert Farr			22e. ADDRESS Chestertown, Maryland 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 23, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Gracelawn			23d. LOCATION CITY OR TOWN Wilmington N.C.			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Edward Fellows & Son			ADDRESS Millington, Md.			25a. DATE REC'D. BY REGISTRAR MAY 25 1983			25b. REGISTRAR'S SIGNATURE <i>J. L. Cabell</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 | 3 6 3 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Ada	Myrtle	Wallace	May 5, 1983			P 5:43 M		
3. SEX			4. RACE		5. DATE OF BIRTH						
Female			White		MONTH Dec. YEAR 1902						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.			U.S.A.				Kent			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown			Kent and Queen Anne's Hospital			Housewife			Home		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS					
Md.			Kent	Betterton		Erickson Ave;			21610		
14. FATHER'S NAME			FIRST William	MIDDLE	LAST Rolph	15. MOTHER'S MAIDEN NAME					
						FIRST Clara	MIDDLE	LAST McClain			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		
No.			185-01-2875			Son. Lester A. Wallace, Box 1030, Willis,			Texas 77378		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4100			Recurrent Myocardial Defarction Severe right			5		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Due to, or as a consequence of Previous Myocardial Defarction						4100		
			(c) Due to, or as a consequence of						5/183		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Partial Small Bowel Obstruction due to incarcerated inguinal hernia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>REC.</u> , 19 71, to <u>REC.</u> , 19 83, that (I) (we) last saw the deceased alive on <u>REC.</u> , 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>C.G. BAUMANN MD</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>5/9/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C.G. BAUMANN MD</u>			22e. ADDRESS <u>CHESTERTOWN, MD 21620</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			5/10/83	Millington Cem.		Millington, Kent, Md.					
24. FUNERAL DIRECTOR NAME <u>Edward Fellows & Son, Millington, Md.</u>			21651			25a. DATE REC'D. BY REGISTRAR IN REGISTRATION NATURE <u>MAY 17 1983 John J. Smith</u>					

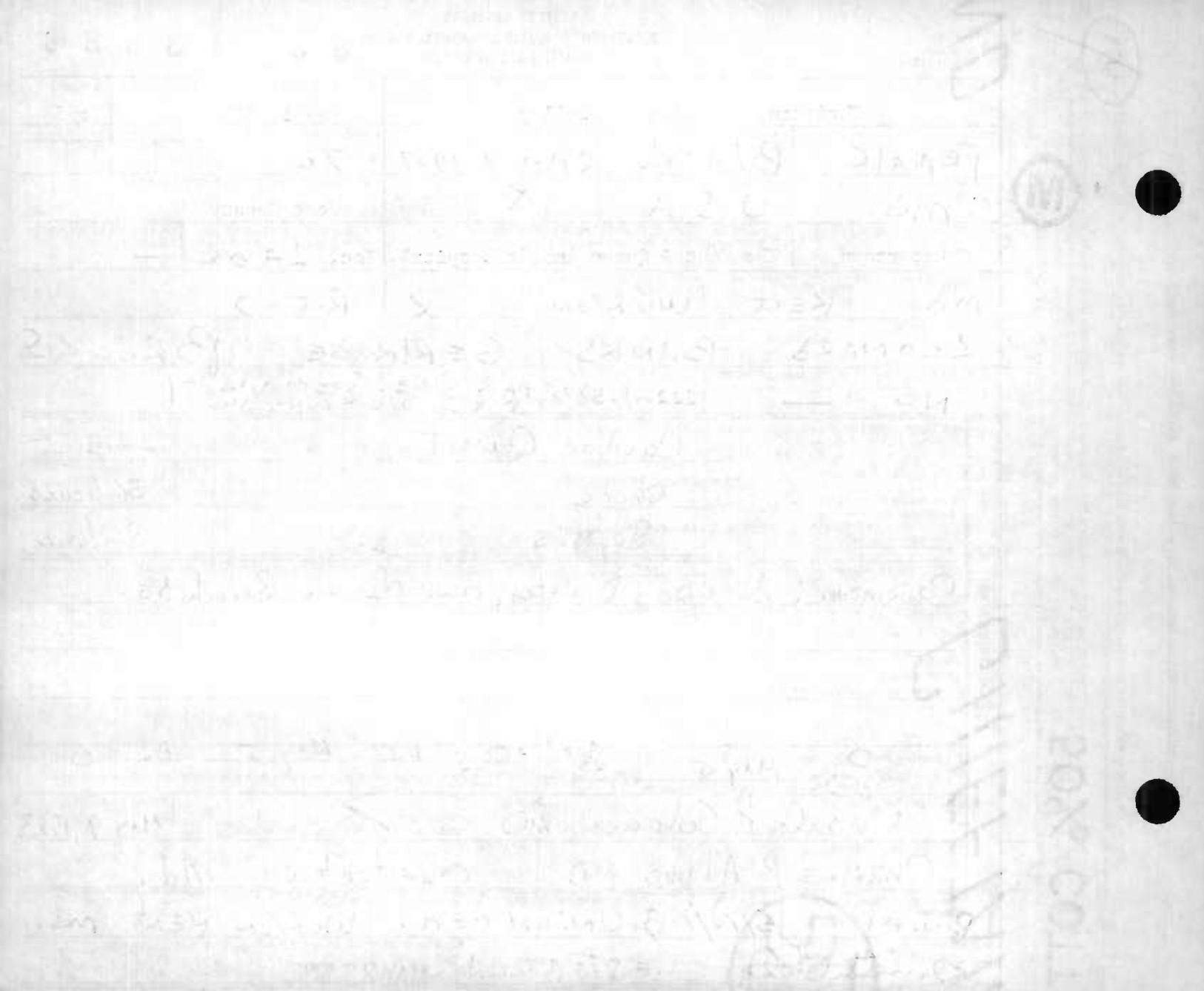
the center of the city
and the surrounding
area. The city is
located on a hillside
with a river flowing
through it. The city
is surrounded by
forests and mountains.
The city has a mix
of modern and traditional
architecture. There
are many temples,
mosques, and churches
in the city. The city
is also known for its
cultural diversity.
There are many different
ethnic groups living
in the city. The city
is a major center for
trade and commerce.
The city is also a
major center for
tourism. The city
has many beautiful
natural landmarks.
The city is also a
major center for
education. The city
has many universities
and colleges.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8313638			
										REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							2b. HOUR			
(TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH	DAY	YEAR		A			
Christine			Ann	Walley	May 5, 1983			9:55 M					
3. SEX			4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
FEMALE			BLACK		JAN. 17, 1907			76	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.			
7. PLACE (COUNTRY)			8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Md.			U.S.A.		Kent County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Chestertown			The Kent & Queen Anne's Hospital, Inc.							12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.			Kent		Worton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		B.F.D. 21678			
14. FATHER'S NAME			FIRST		LAST			15. MOTHER'S MAIDEN NAME					
LEONARD					BANKS			GERTRUDE			BROOKS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			222-18-5875		M.R. PRESTON M. WALLEY						immediate		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			0389 IMMEDIATE CAUSE (a) Cardiac Arrest										
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Shock							36 hours.			
			DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis							36 hours.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Carcinoma; ASCVD; Diabetes; and Chronic Bronchitis.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
										YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from April 28, 1983, to May 5, 1983, that <input type="checkbox"/> (we) last saw the deceased alive on May 5, 1983, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (We) did not view the body after death.													
22b. SIGNATURE Charles P. Adams			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED May 9, 1983					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles P. Adams MD.			22e. ADDRESS Chesapeake, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5/10/1983		23c. NAME OF CEMETERY OR CREMATORIAL UNION CEM.			23d. LOCATION CITY OR TOWN Worton		COUNTY	STATE		
24. FUNERAL DIRECTOR Name _____ Address _____			25a. DATE REC'D. BY REGISTRAR MAY 23 1983							25b. REGISTRAR'S SIGNATURE John J. Smith			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

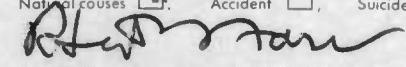
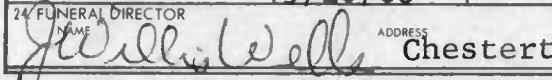
IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 3 6 3 9				
										REG. NO.				
1 - STATE REGISTRAR		I DECEASED NAME (TYPE OR PRINT)			FIRST LAVINIA	MIDDLE M.	LAST WALLIS	2a. DATE OF DEATH	MONTH May	DAY 29	YEAR 1983	2b. HOUR 130 A M		
3 SEX female		4 RACE white			5 DATE OF BIRTH MONTH May DAY 29 YEAR 1910			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.						
10 CITY OR TOWN OF DEATH Rock Hall RFD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home Hinchingham Farm			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY RFD Hinchingham Farm						
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21661 RFD Hinchingham Farm						
14 FATHER'S NAME Frank H. Mackie					15 MOTHER'S MAIDEN NAME Emma B. O'Connell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220 46 3272			17 INFORMANT Holly Van de Wal			ADDRESS Joppa, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardia</i> I <i>refract</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriovenous heart disease</i> Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <i>Several years</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN						
22a. I certify that (I) <i>(This hospital)</i> attended the deceased from <i>June 19 79</i> to <i>May 29 1983</i> , that (II) <i>(I did)</i> saw the deceased alive on <i>June 19 79</i> , and that in (my) <i>I</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(I did)</i> view the body after death.										COUNTY STATE				
22b. SIGNATURE <i>A. C. Dick</i>		DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/30/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. Dick		22e. ADDRESS Chestertown, Md. 21620												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/31/83		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery near Chestertown, Md.			23d. LOCATION CITY OR TOWN			COUNTY STATE				
24. FUNERAL DIRECTOR NAME <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR JUN 2 1983			25b. REGISTRAR'S SIGNATURE <i>Bea C. Clark</i>						

BP _____

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 3 6 4 0	NOON			
1 - STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/> MONTH DAY YEAR 5/23/1983			2b. HOUR 12:00A				
			LOUISE WALLS													
SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD May 23, 1983			2d. MONTH DAY YEAR 24 1983	
female		white		12/8/1897		85						DEAD			12:15P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co.							
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Court House Lawn						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Maple Ave. 21620					
14. FATHER'S NAME FIRST William Clayton MIDDLE (Sr.) LAST									15. MOTHER'S MAIDEN NAME FIRST Myra MIDDLE Ayers LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 201 07 2557						17. INFORMANT ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: ASCVD												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4292 IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) _____ } DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22b. TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				
ACTUAL SIGNATURE 			DATE SIGNED 5/23/83													
EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr Kent County			ADDRESS, Chestertown, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/26/83			23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md. 21620			23e. COUNTY COUNTY				
24. FUNERAL DIRECTOR NAME 			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR MAY 31 1983			25b. REGISTRAR'S SIGNATURE 							
BP																
DHMH - 17 (VR A15 ME (5)) 15M 7/77																

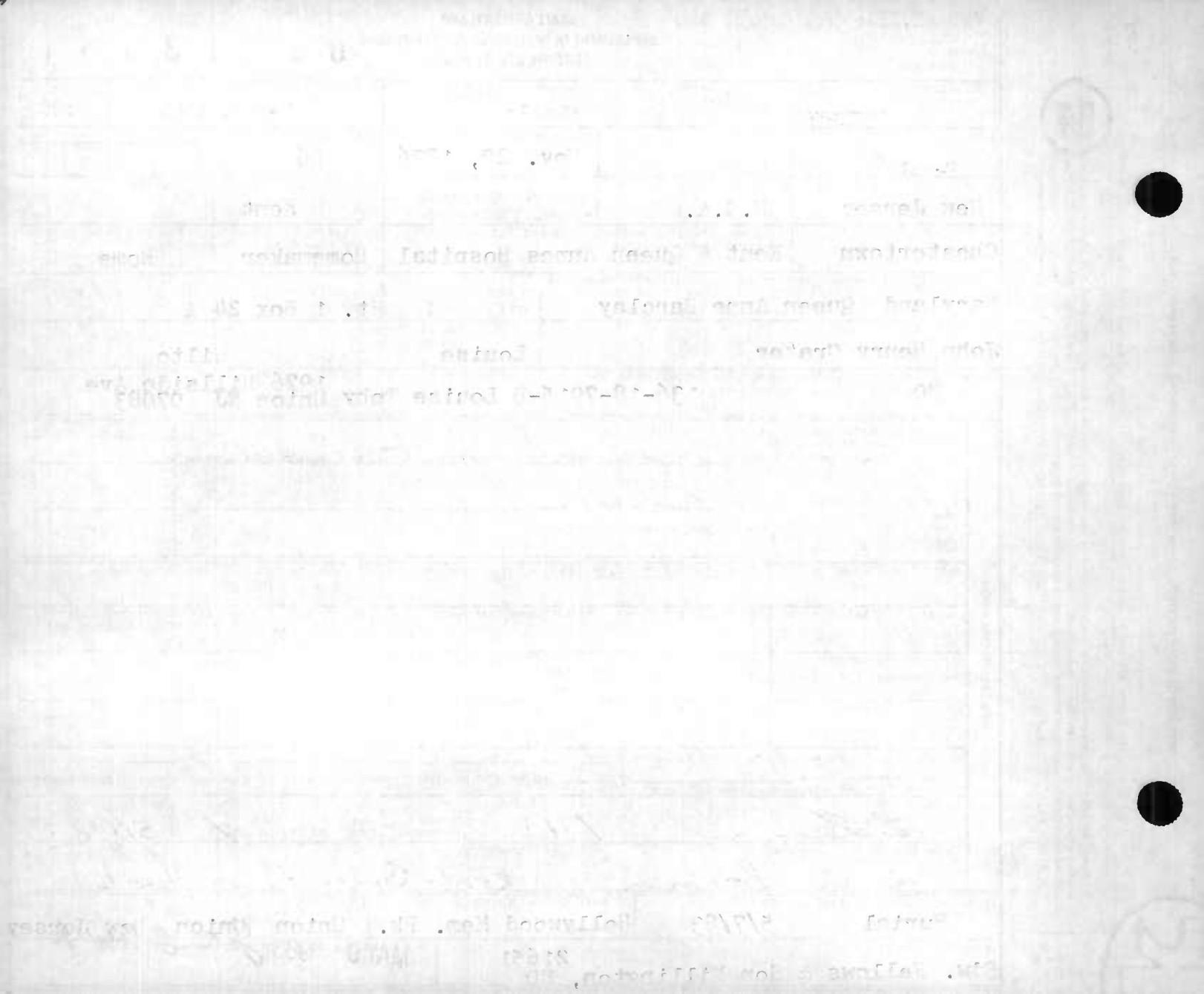
water bath

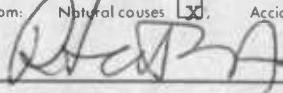
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8 3 1 3 6 4 1 REG. NO.													
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST AKA Mamie MIDDLE Whible LAST Whible			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
		Margaret						May 4, 1983			9:00 P M		
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		White			Nov. 20, 1896			86			YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
New Jersey		U.S.A.						Kent					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		Kent & Queen Anne's Hospital						Homemaker			Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Queen Anne		Barclay					Rt. 1 Box 24 A			21607	
14. FATHER'S NAME		LAST			15. MOTHER'S MAIDEN NAME			LAST					
John Henry Crater					Louise			Wilton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			1978 Hillside Ave			ADDRESS		
NO		136-18-7915			B Louise Toby			Union NJ 07083					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) myocardial infarction & cardiac arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE B. Berman		DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 5/9/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Berman		22e. ADDRESS Kent Queen Anne's Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b. DATE 5/7/83			23c. NAME OF CEMETERY OR CREMATORIAL Hollywood Mem. Pk.			23d. LOCATION CITY OR TOWN Union			COUNTY STATE Union New Jersey		
24. FUNERAL DIRECTOR NAME Edw. Fellows & Son Millington, MD		ADDRESS 21651			25a. DATE REC'D. BY REG. OFFICER/REG. REGISTRAR MAY 9 1983			25b. REGISTRAR'S SIGNATURE John J. Newell					



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	3 6 4 2			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR	2b. HOUR			
			Bessie			Whye			<input type="checkbox"/>			May 1, 1983	12:30			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d. HOUR	
Female		Black		12-10-1919		63						May 1, 1983		2:15		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			USA						Kent							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Worton			At Home						Labor							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21678				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		R.F.D.#						
Maryland		Kent		Worton												
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Gilbert Hill			Mary													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS										
No			YES			Mrs. Marie Jones Baltimore 16 Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												DATE SIGNED 5-4-83				
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)			Robert W. Farr, M.D.			ADDRESS Chestertown, Maryland 21620										
23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/> Burial			23b. DATE May 5, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive Cemetery			23d. LOCATION CITY OR TOWN Worton, Kent, Maryland			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME 			ADDRESS Chestertown, MD			25a. DATE REC'D. BY REGISTRAR MAY 5 1983			25b. REGISTRAR'S SIGNATURE 							
BP _____																
DHMH - 17 (VR A15 ME (5)) 15M7/77																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	3	1	3	6	4	3	
												REG. NO.							
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
			Helen			Elizabeth Willson			5 / 17 / 83						11:21PM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
female			white			12/6/1903			79			MONTHS	YEARS	MONTHS	HOURS	MIN.			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland			USA						Kent										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Chestertown			Kent and Queen Anne's Hospital			Registered Nurse													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21661				
Md.			Kent			Rock Hall						Sharp St.							
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME													
Richard Loehoffer						Lena													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>+292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio-occlusive Cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>a prob. cardiac arrhythmia</i>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no			217 52 6073																
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c.) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a acute pancreatitis = cholelithiasis																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>5-17</i> , 19 <i>83</i> , to <i>5-17</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>5-17</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>Harry Paul Ross MD</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS			22e. DATE SIGNED <i>5-20-83</i>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Paul Ross																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/20/83			23c. NAME OF CEMETERY OR CREMATORIAL St. Paul Cemetery near Chestertown, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE										
24. FUNERAL DIRECTOR NAME <i>Willis Wells</i>			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR MAY 27 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conigli</i>										

